Date: [Insert Date]

To:
Custodian of Medical Records
[Name of Facility/Clinic]
[Address]
[City, State, Zip Code]

RE: Letter of Instruction for Certified Medical Records Release

Patient Name: [Full Name of Patient]
Date of Birth: [Patient DOB]
Social Security Number (Optional/Last 4): [XXX-XX-XXXX]
Date of Service/Treatment Range: [Insert Dates]

To Whom It May Concern,

I am writing to formally request a complete copy of my medical records for the period indicated above. Please ensure that these records are **certified** as true and complete copies of the original files.

The requested records should include, but are not limited to:

- Physician notes and summaries
- Diagnostic test results and lab reports
- Imaging reports (X-rays, MRI, CT scans)
- Prescription and medication history
- Billing and insurance records

Please deliver the certified records to the following recipient:

Recipient Name: [Name of Person or Organization]
Address: [Full Mailing Address]
Method of Delivery: [E.g., Secure Email, Certified Mail, or Pickup]

I understand that there may be a reasonable fee associated with the duplication and certification of these records. Please notify me in advance if the cost exceeds $[Insert Amount].

Attached to this letter is my signed Authorization for Release of Health Information as required by HIPAA regulations.

Thank you for your prompt attention to this matter. Please complete this request within [Number] days of receipt.

Sincerely,

[Signature]

[Printed Name]
[Phone Number]
[Email Address]